



Department of Employment Dispute Resolution

MEDIATION REQUEST

(To be completed by Agency Workplace Mediation Coordinator, then faxed to EDR)

Please fill in all areas completely.

(date)

Agency Workplace Mediation Coordinator Conducting Intake:

(name)

(phone #)

(fax #)

email address

Agency: _____

Facility: _____

Dept. _____

Do the concerns potentially involve persons in addition to those listed as participants? ☐ yes ☐ no

(If "yes," please specify.) _____

Background of dispute/issues:

Special considerations or accommodations requested (*EDR will make reasonable accommodations as provided by the ADA and will attempt, where possible, to assign mediators providing the greatest comfort level for participants*):

I have informed the participants of the roles and responsibilities of participants and mediators by giving them a copy of "Information about the Mediation Process" and "Tips for Successful Mediation Participation" and how to contact EDR for further information. ☐ yes ☐ no

 ➡ *For a two-party dispute, complete and fax Pages 1 & 2*
 ➡ *For a group dispute, complete and fax Pages 1 & 3*

FAX to Mediation Staff at (804)371-7318 (786-7994, phone)

For EDR use only:

Received: _____
date

Approved for mediation: _____
name date

Comments: _____

MEDIATION REQUEST (TWO-PARTY DISPUTE)

FIRST PARTICIPANT:

Name: _____ Gender: Male _____ Female _____

Working Title: _____ Pay Band: _____ Work Phone: _____

Mailing Address: _____

E-mail: _____

WORKING RELATIONSHIP TO THE SECOND PARTICIPANT:

- ☐ Supervises the other party
☐ Supervised by the other party
☐ Does not supervise the other party directly, but is in the other party's chain of command
☐ Is not supervised by the other party, but the other party is in this employee's chain of command
☐ co-worker

SECOND PARTICIPANT:

Name: _____ Gender: Male _____ Female _____

Working Title: _____ Pay Band: _____ Work Phone: _____

Mailing Address: _____

E-mail: _____

WHO REFERRED THE PARTICIPANTS TO MEDIATION?

- | | |
|--|---|
| <input type="checkbox"/> Self | <input type="checkbox"/> Agency Workplace Mediation Coordinator |
| <input type="checkbox"/> Supervisor | <input type="checkbox"/> EDR staff |
| <input type="checkbox"/> HR Staff Member | <input type="checkbox"/> other (specify) |

The participants are choosing mediation:

- ☐ as early intervention (there is no plan at this time to file a grievance)
☐ in lieu of initiating a grievance at this time and putting the grievance on hold until mediation is concluded
☐ after the conclusion of a grievance process

PROVIDE AT LEAST FIVE DATES, MUTUALLY AGREED UPON BY THE PARTIES, FOR THE MEDIATION SESSION (mediation sessions typically last 3-8 hours): ***NOTE: THE DATES SHOULD BEGIN NO SOONER THAN 5 WORKDAYS FROM THE DATE REQUEST FORM IS SENT TO EDR.***

*Fax along with Page 1 to Mediation Staff at (804)371-7318 (786-7994, phone).
 Questions about this form – contact Mediation Staff.
 Thank you.*

MEDIATION REQUEST (GROUP DISPUTE)

BACKGROUND:

Number of employees in work group: _____

Type of work performed: _____

Length of time issues have existed: _____

Avenues management has pursued to resolve issues:

PARTICIPANTS:

(name & title)

(name & title)

(name & title)

(name & title)

(name & title)

(name & title)

(name & title)

(name & title)

(name & title)

(name & title)

(use back of this page if more space is needed)

READINESS FOR MEDIATION:

Is the agency management committed to provide the time and support needed to complete the process?
 ___yes ___no

Has management informed the participants of the request for group mediation? ___yes ___no

If so, what was the response? _____

PROVIDE AT LEAST THREE DATES, MUTUALLY AGREED UPON BY THE POTENTIAL PARTICIPANTS, FOR THE PRE-MEDIATION INFORMATION SESSION (this session typically lasts 30-90 minutes):

***Fax along with Page 1 to Mediation Staff at (804)371-7318 (786-7994, phone).
 Questions about group mediation – contact Mediation Staff at 804-786-7994.
 Thank you.***